

**FAIRFAX COUNTY
DEPARTMENT OF HOUSING AND COMMUNITY DEVELOPMENT
FIRST-TIME HOMEBUYERS PROGRAM
ACCESSIBILITY PREFERENCE FORM**

>>Please Print In Ink or Type<<

APPLICANT INFORMATION

NAME	Last	First	Middle	DATE OF BIRTH	Social Security Num.
STREET ADDRESS					
CITY			STATE	ZIP CODE	DAYTIME PHONE NUMBER
<p><u>Permanent Disability:</u> <i>I hereby knowingly certify under penalty of fraud that I have a physical impairment and/or traumatic brain injury that is expected to be of a long, continuing and indefinite duration that substantially impedes my ability to live independently without a residence with accessibility features, and that all the information I have provided here is true.</i></p>					
Signature:				Date:	

PHYSICIAN OR LICENSED HEALTHCARE PROFESSIONAL CERTIFICATION

(To be completed by Physician or other regular Healthcare Provider)

<p>I certify and affirm that the above described applicant is my patient/client whose ability to walk or climb stairs, in my professional opinion, is limited or impaired such that the impairment is expected to be of a long, continuing and indefinite duration and substantially impedes the patient's ability to live independently without a residence with accessibility features.</p>			
LICENSED HEALTHCARE PROVIDER'S NAME (please print or type)			Date
License Number	License Expiration Date	State Issuing License	Office Telephone Number
Physician's/Healthcare Provider's Signature			Office Fax Number